Comparison of health plan benefits offered for 2004

TYPE	PREFERRED PROVIDER ORGANIZATION To receive the higher level of benefits, subscribers should choose an in-network provider.		TRADITIONAL HMO All care must be directed by a primary care physician (PCP) and approved by the HMO.		HMO WITH POINT OF SERVICE (POS) OPTION To receive the higher level of benefits, care must be directed by a primary care physician (PCP) and approved by the HMO. Medically necessary benefits are available out-of-network at a lower benefit level.			
PLAN	**SHP ECONOMY PLAN**	**SHP STANDARD PLAN**	**COMPANION HMO**	**CIGNA HMO**	**COMPANION-CHOICES POS**		**MUSC Options**	
SERVICE AREAS	• Coverage worldwide	• Coverage worldwide	• Service areas: 3, 4, 5, 6, 7, 8, 9, 10, 11, 12	• Service areas: 1, 2, 3, 5, 7, 8, 9, 10, 11, 12	• Service areas: 1, 2		• Service area: 11	
ACTIVE EMPLOYEE MONTHLY PREMIUMS Employee only: Employee/spouse: Employee/children: Full family:	 $ 66.48 $170.12 $ 96.10 $206.20	 $ 69.50 $189.58 $106.52 $234.68	 $ 77.08 $218.46 $179.36 $382.86	 $ 74.56 $213.10 $175.10 $375.62	 $ 86.10 $238.38 $195.08 $410.08		 $ 72.28 $194.68 $143.36 $296.08	
ANNUAL DEDUCTIBLE Single Family	$500 $1,000	$350 $700	None	None	<u>In-network</u> None	<u>Out-of-network</u> $500 per individual	<u>In-network</u> None	<u>Out-of-network</u> $300 $900
HOSPITALIZATION/EMERGENCY CARE	Outpatient hospital: $75 per-occurrence deductible Emergency care: $125 per-occurrence deductible	Outpatient hospital: $75 per-occurrence deductible Emergency care: $125 per-occurrence deductible	Inpatient: $200 copay Outpatient: $75 copay/first 3 visits Emergency care: $75 copay	Inpatient: $500 copay Outpatient facility: $250 copay Emergency care: $100 copay	Inpatient: $200 copay Outpatient Surgery: $75 copay/first 3 visits Emergency care: $75 copay	Inpatient: $250 copay Outpatient Surgery: $125 copay Emergency care: $75 copay	Inpatient: $300 copay Outpatient Facility: $100 copay Emergency care: $100 copay	Annual deductibles for inpatient and outpatient care Emergency care: $100 copay
COINSURANCE	<u>In-network</u> Plan pays 75% You pay 25% | <u>Out-of-network</u> Plan pays 55% You pay 45%	<u>In-network</u> Plan pays 80% You pay 20% | <u>Out-of-network</u> Plan pays 60% You pay 40%	HMO pays 90% after copays You pay 10%	HMO pays 80% after copays You pay 20%	HMO pays 90% after copays; You pay 10%	HMO pays 70% after deductible and copays	HMO pays 100% after copays	HMO pays 60% of allowance You pay 40%
COINSURANCE MAXIMUM	$2,000 $4,000 (excludes deductible)	$2,000 $4,000 (excludes deductible)	$1,500 $3,000 (excludes copays)	$3,000 (includes inpatient, out-patient copays & coin-surance) $6,000	$1,500 $3,000 (excludes copays)	$3,000 (excludes copays and deductible) $6,000	N/A	$3,000 $9,000 (excludes deductibles)
PHYSICIAN VISITS	$10 per visit deductible then: <u>In-network</u> Plan pays 75% You pay 25% | <u>Out-of-network</u> Plan pays 55% You pay 45%	$10 per visit deductible then: <u>In-network</u> Plan pays 80% You pay 20% | <u>Out-of-network</u> Plan pays 60% You pay 40%	$15 PCP copayment $15 OB/GYN well woman exam $25 specialist copay $35 urgent care copay	$20 PCP copayment $40 OB/GYN well woman exam $40 specialist copay	$15 PCP copay $15 OB/GYN well woman exam $25 specialist copay $35 urgent care copay	Coinsurance: HMO pays 70% of allowance after annual deductible You pay 30%	$15 PCP copay $15 OB/GYN well woman exam $25 specialist copay with referral $45 specialist copay without referral	Coinsurance: HMO pays 60% of allowance after annual deductible You pay 40% No preventive care benefits out-of-network
PRESCRIPTION DRUGS	Participating pharmacies only: $10 generic $25 preferred brand $40 nonpreferred brand (up to 31-day supply) Mail-order (up to 90-day supply): $23 generic, $56 preferred brand; $90 non-preferred brand Out-of-Pocket Max: $2,500	Participating pharmacies only: $10 generic $25 preferred brand $40 nonpreferred brand (up to 31-day supply) Mail-order (up to 90-day supply): $23 generic, $56 preferred brand; $90 non-preferred brand Out-of-Pocket Max: $2,500	Participating pharmacies only (Generics First): $7 generic $25 preferred brand $40 nonpreferred brand $75 specialty pharmaceuticals (31-day supply) Mail-order (up to 90-day supply) $21 generic; $75 preferred brand; $120 non-preferred brand	Participating pharmacies only: $10 generic $20 preferred brand $50 nonpreferred brand (30-day supply) Mail-order (up to 90-day supply): $20 generic; $40 preferred brand name; $100 non-preferred brand name	Participating pharmacies only (Generics First): $7 generic $25 preferred brand $40 nonpreferred brand $75 specialty pharmaceuticals (31-day supply) Mail-order (up to 90-day supply): $21 generic; $75 preferred brand name; $120 non-preferred brand name		Participating pharmacies only: $10 generic $25 preferred brand $40 nonpreferred brand (31 day supply) Mail-order available (90-day supply): $15 generic, $50 preferred brand, $80 non-preferred brand	
MENTAL HEALTH/ SUBSTANCE ABUSE	Participating providers only. Call 1-800-221-8699. Subject to above deductibles and coinsurance.	Participating providers only. Call 1-800-221-8699. Subject to above deductibles and coinsurance.	Participating providers only. Call 1-800-868-1032. Inpatient: $200 copay, then 90% covered; Outpatient: $25 specialist copay	Participating providers only. Inpatient: $500 copay, then 80% covered Outpatient: $40 specialist copay	Participating providers only. Call 1-800-868-1032. Inpatient: $200 copay, then 90% covered Outpatient: $25 specialist copay		Inpatient: $300 copay Outpatient: $25 copay with referral, $45 copay without referral	HMO pays 60%of allowance after annual deductible
LIFETIME MAXIMUM	$1,000,000	$1,000,000	$1,000,000	$1,000,000	$1,000,000		$1,000,000	